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(AC-In)**

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(2005 documents)

Medical Liability Reform - NOW!
October 19, 2005

A compendium of facts supporting medical liability reform
and debunking arguments against reform.

American Medical Association
515 North State Street
Chicago, Illinois 60610

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I. Identification of the Problem

A. Recurrence of an Old Problem?

1. The medical liability insurance system experienced a period of crisis in the early 1970s, when several private insurers left the market because of rising claims and inadequate rates.
2. This exodus of capacity resulted in an availability crisis and created an affordability issue for those physicians and hospitals lucky enough to find insurance.
3. Over the next fifteen years, various attempts were made to ease the explosion in claims costs: tort reform, increased diagnostic testing, improved peer review and increased communication between physicians and patients. Aggressive campaigns to reform state laws governing medical liability lawsuits began in the 1970s and were successful in a number of states including California, Louisiana, Indiana and New Mexico.

1. In California, in particular, between 1968 and 1974, the number of medical liability claims doubled and the number of losses in excess of \$300,000 increased 11-fold, from 3 to 34. Losses amounting to \$180 for each \$100 of premium led most commercial insurers to conclude that the practice of medicine was uninsurable, and they refused to provide medical liability insurance at any price. In California, access to care was threatened, and a special session of the California legislature led to enactment of the Medical Injury Compensation Reform Act of 1975 (MICRA).¹

B. Second Liability Crisis: 1980s

1. During the 1980s, the second crisis – one of affordability – shook the industry, as claim frequency and severity increased again and premiums rose rapidly.
2. The affordability crisis had a dramatic effect. Physicians in specialties such as obstetrics and gynecology cut back on high-risk procedures and high-risk patients to reduce their risks and hold down their premiums.
3. Some physicians closed practices in states where premiums and the risk of being sued were especially high.

C. The Current Liability Crisis: Trends in Jury Awards and Settlements

¹Richard E. Anderson, *Commentaries Defending the Practice of Medicine*, 164 ARCHIVE OF INTERNAL MED. 1173, 1173-4 (June 14, 2004).

1. Recent data from the Physician Insurers Association of America illustrates the problem as it exists today.²
 - a. The median medical liability jury award in medical liability cases close to tripled from 1997 to 2004, increasing from \$157,000 to \$439,400.³ The average award increased from \$347,134 in 1997 to \$606,907 in 2004.⁴
 - b. Settlements have also grown in size. Median and average settlements increased from \$100,000 to \$190,000, and from \$212,861 to \$311,704 between 1997 and 2004, respectively.⁵
 - c. Overall, 75% of medical liability claims in 2004 were closed without payment to the plaintiff.⁶ Plaintiffs lost the majority of the cases that went to a jury. Of the 7% of claims that went to jury verdict, the defendant won 83% of the time.⁷
 - d. However, physicians who win at trial still have large fees to pay for their defenses. Average defense costs were \$93,559 per claim in cases where the defendant prevailed at trial.⁸ And in cases where the claim was dropped or dismissed, costs to defendants averaged \$18,774.⁹
2. The severity of very large awards is increasing. According to a recent study by the Blue Cross/Blue Shield Association, plans in crisis states believe that inappropriately large jury verdicts are the primary factor contributing to increasing medical liability premiums.¹⁰
3. Jury Verdict Research (JVR) provides summary statistics on the small percentage of claims that reach the trial stage. The estimates from the Physician Insurers Association of America (PIAA) provide a broader picture of closed claims because they include claims that are dropped and settled in addition to those that are tried. PIAA also provides information on defense costs while JVR does not. Despite the more limited scope of the JVR estimates, they also show that awards are increasing.

² PHYSICIAN INSURERS ASS'N OF AM., PIAA CLAIM TREND ANALYSIS: 2004 ed. (2005).

³ *Id.* at exhibit 6a-2.

⁴ *Id.*

⁵ *Id.* at exhibit 6b-2.

⁶ *Id.* at exhibit 1.

⁷ *Id.* at exhibits 1, 6a.

⁸ *Id.* at exhibit 6a-4.

⁹ *Id.* at exhibit 6b-4.

¹⁰ BLUE CROSS BLUE SHIELD ASS'N, THE MALPRACTICE INSURANCE CRISIS: THE IMPACT ON HEALTHCARE COST AND ACCESS 3 (2003).

D. The Current Liability Crisis: Access to Care

1. 82% of Americans believe that physicians are being forced to leave their practices because excessive litigation puts the cost of liability insurance out of reach.¹¹
2. A poll showed that 74% of Americans favor a law that guarantees full payment of lost wages and medical expenses but reasonably limits the amount that can be awarded for pain and suffering in medical liability cases.¹²
3. A study found that between 1975 and 2000, the number of obstetricians in states which had enacted caps in the 1980s rose five times more than states without caps.¹³
4. Forty-five percent of hospitals reported that the professional liability crisis has resulted in the loss of physicians and/or reduced coverage in emergency departments.¹⁴ For the rest of the states, over half of the Blue Cross/Blue Shield plans feel it is an “inevitable” problem.¹⁵
5. A Blue Cross/Blue Shield survey shows that rising medical liability premiums are causing access and cost problems in crisis states.¹⁶
6. 99% of AMA members surveyed are very or somewhat concerned about the current medical liability environment, with 87% being very concerned. One-third of the members surveyed have begun referring complex cases in the last twelve months and 98% reported that medical liability pressures were important in their decision. Twenty-seven percent of member physicians have stopped providing certain services in the last twelve months and 96% of them indicate that medical liability pressures were important in their decision.¹⁷
7. Residents’ Concerns
 - a. Medical residents’ growing concerns about liability issues may cause them to avoid choosing high-risk specialties or practicing in a crisis state. 62% of medical residents reported that liability issues were their top concern in

¹¹ Wirthlin Worldwide, 2004

¹² Health Coalition on Liability and Access, *Poll Shows Americans Want Congress to Support Comprehensive Medical Liability Reform* (2005), available at <http://www.hcla.org/polls.html> (last visited October 31, 2005).

¹³ *Malpractice Awards Rose in 1991-2003 At Annual Rate of 4%, Study Finds*, HEALTH CARE DAILY, June 1, 2005.

¹⁴ AM. HOSP. ASS’N., PROF’L LIABILITY INS. SURVEY (2003).

¹⁵ *Id.* at 8.

¹⁶ BLUECROSS BLUESHIELD ASS’N, *supra* note 10, at 4.

¹⁷ DIV. OF MKT. RESEARCH & ANALYSIS, AM. MED. ASS’N, AMA MEMBER CONNECT SURVEY: 2004 MED. LIABILITY REFORM SURVEY (2004), available at <http://www.ama-assn.org/ama1/x-ama/upload/mm/450/memberconnectmlr3.pdf> (last visited Sept. 29, 2005).

2003—surpassing any other concern, and representing an enormous increase from 2001, when only 15% of residents said liability was a concern.¹⁸

- b. Some medical residents report the current medical liability system also works against physicians trying to practice evidence-based medicine (EBM). One recent example is from a resident who, despite utilizing the best practices of EBM, watched in horror as he was sued and the plaintiff's attorney portrayed EBM as nothing more than "a cost-saving method," and "the few lives saved were not worth the money." Thus, despite the resident showing how he followed "conscientious, explicit, and judicious use of the current best evidence in making clinical decisions about the care of individual patients," the plaintiff's attorney used it against him. The resident was exonerated, but the residency program was found liable for \$1 million.¹⁹
- c. Even in states with caps, such as Wisconsin, residents may not be protected from massive damage awards. In October, 2004, a loophole in Wisconsin's \$500,000 non-economic damages cap was exploited to permit a total award of more than \$26 million against a resident, who was found to not be protected by the cap because he was not yet a fully licensed physician.²⁰

8. Students' Concerns

- a. Students, too, are affected by the current crisis. In fact, half of the respondents of a recent AMA survey indicated the current medical liability environment was a factor in their specialty choice.
- b. Thirty-nine percent said the medical liability environment was a factor in their decision about a state in which they would like to complete residency training.
- c. Sixty-one percent of students reported they are extremely concerned the current medical liability environment is decreasing physicians' ability to provide quality medical care.

¹⁸ MERITT, HAWKINS & ASSOC., SUMMARY REPORT: 2003 SURVEY OF FINAL YEAR MED. RESIDENTS 5 (2003).

¹⁹ Daniel Merinstein, *Winners and Losers* 291 JAMA 15, 15-6 (2004).

²⁰ Derrick Nunnally, *Payout in death may be state's biggest— But challenge looms for 'loophole' allowing jury to ignore malpractice cap*, MILWAUKEE J. SENTINEL, Oct. 23, 2004.

- d. Forty-eight percent of students in their third or fourth year of medical school indicated the liability situation was a factor in their specialty choice.²¹

E. The Current Liability Crisis: Costs

1. Altogether, medical liability adds billions to the cost of health care each year – which means higher health insurance premiums and higher medical costs for all Americans, according to estimates in a recent U.S. Department of Health and Human Services report.²²
2. On September 25, 2002, HHS issued an update on the medical liability crisis. This update reported on the results of a survey conducted by Medical Liability Monitor (MLM), an independent reporting service that tracks medical professional liability trends and issues. Based on the MLM data, HHS concluded that the crisis had become worse.²³ The federal government reported that:

The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of liability insurance coverage. Premiums are spiking across all specialties in 2002. When viewed alongside previous double-digit increases in 2000 and 2001, **the new information further demonstrates that the litigation system is threatening health care quality for all Americans as well as raising the costs of health care for all Americans.** (emphasis added)²⁴

3. HHS also stated that the direct cost of medical liability coverage and the indirect cost of defensive medicine increases the amount the federal government must pay for Medicare, Medicaid, the State Children's Health Insurance Program, Veterans' Administration health care, health care for federal employees, and other government programs by \$33.7 to \$56.2 billion per year.²⁵
4. HHS issued its third report on the medical liability crisis on March 3, 2003. This report provided updated figures documenting the scope of the crisis, including a revised update on the costs borne by the federal government. This report found that direct tort reform,

²¹ DIV. OF MKT. RESEARCH & ANALYSIS, AM. MED. ASS'N, AMA SURVEY: MED. STUDENTS' OPINIONS OF THE CURRENT MED. LIABILITY ENV'T (2003), available at <http://www.ama-assn.org/ama1/pub/upload/mm/31/ms-mlrhighlights.pdf> (last visited Feb. 16, 2004).

²² OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 11 (2003) [hereinafter ADDRESSING THE NEW HEALTH CARE CRISIS].

²³ See OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., UPDATE ON THE MEDICAL LITIGATION CRISIS: NOT THE RESULT OF THE "INSURANCE CYCLE" (2002) [hereinafter INSURANCE CYCLE], available at http://heal-fl-health-care-pdf.netcomsus.com/resources_update_report.doc (last visited Feb. 3, 2004).

²⁴ *Id.* at 3.

²⁵ ADDRESSING THE NEW HEALTH CARE CRISIS, *supra* note 23.

including but not limited to reasonable limits on non-economic damages (e.g., pain and suffering, mental anguish, physical impairment, etc.), would reduce the amount of taxpayers' money the federal government spends by \$28.1 to \$50.6 billion per year.²⁶

5. Evidence that the litigation system is broken is further established in a study released by Tillinghast-Towers Perrin on May 17, 2005. **Medical liability costs have risen an average of 11.8% a year since 1975, outpacing increases in overall U.S. tort costs (9.2%).**²⁷
 - a. Tillinghast reported that U.S. tort costs grew by 8.7% from 2002 to 2003.²⁸ This is the only study that tracks the cost of the U.S. tort system from 1950 to 2002 and compares the growth of tort costs with increases in various U.S. economic indicators.
 - b. In 2003, medical liability costs translated to \$91 per person, according to Tillinghast.²⁹
 - c. Tillinghast reported that U.S. tort costs grew by 5.4% in 2003. This growth outpaced the trend of the past decade and "exceeded overall economic growth of 4.9%."³⁰
6. The vast majority of medical liability claims, 75%, do not result in any payments to patients.³¹ Only 1% of cases result in trial victories for plaintiffs.³²
7. Blue Cross/Blue Shield's health plans report that approximately half of the plans expect Ob-Gyn (obstetrical and gynecological) and surgical fees to increase as a result of increased professional liability premiums.³³
8. Patients are aware of the impact of lawsuits on healthcare costs. Seventy-one percent (71%) agree that medical liability litigation is driving up health care costs.³⁴
9. An April 2002 PricewaterhouseCoopers study "The Factors Fueling Rising Healthcare Costs" concluded that litigation

²⁶ *Id.* at 11..

²⁷ TILLINGHAST-TOWERS PERRIN, U.S. TORT COSTS: 2004 UPDATE: TRENDS AND FINDINGS ON THE COST OF THE U.S. TORT SYSTEM (2004), available at http://www.towersperrin.com/tillinghast/publications/reports/Tort_2004/Tort.pdf (last visited October 11, 2005).

²⁸ *Id.* at 15.

²⁹ *Id.* at 1.

³⁰ *Id.* at 2.

³¹ PHYSICIAN INSURERS ASS'N OF AM., *supra* note 2, at exhibit 1.

³² *Id.*

³³ BLUE CROSS BLUE SHIELD ASS'N, *supra* note 10, at 2.

³⁴ WIRTHLIN WORLDWIDE, THE MED. LIABILITY CRISIS: A FED. PROBLEM THAT REQUIRES A FED. SOLUTION, available at <http://www.hcla.org> (Last visited Feb. 12, 2004).

accounted for 7% of the increase in rising costs of health insurance premiums. "Litigation" includes the effects of defensive medicine, liability premiums, risk management and reinsurance, outsized awards and legal costs, and class action lawsuits.³⁵

F. The Current Liability Crisis: Defensive Medicine

1. Defensive medicine practices include tests and treatments that are performed to help avoid lawsuits.
 - a. A majority (59%) of physicians believe that the fear of liability discourages open discussion and thinking about ways to reduce health care errors.³⁶
 - b. Over three-fourths (76%) of physicians believe that concern about medical liability litigation has negatively affected their ability to provide quality care in recent years.³⁷
2. The costs of defensive medicine are estimated to be between \$70-\$126 billion per year. These costs could be significantly reduced by medical liability reforms.³⁸
3. Defensive medicine takes many forms as physicians respond to the breakdown of access to care, including: referring patients to emergency departments, safety net hospitals and academic health centers; specialists declining to take call in the emergency department; and specialists declining elective referrals from emergency departments and safety net clinics, especially for uninsured patients.³⁹
4. 69% of students whose professors discussed the liability situation said the professors also discussed defensive medicine, including increasing unnecessary or excessive care.⁴⁰
5. Of Blue Cross/Blue Shield plans surveyed, those in crisis states are two and a half times more likely to identify defensive medicine as "already a very serious problem" in relation to cost increases.⁴¹

³⁵ PRICEWATERHOUSECOOPERS, AM. ASS'N OF HEALTH PLANS, THE FACTORS FUELING RISING HEALTHCARE COSTS, 3 (2002), available at <http://www.aahp.org/InternalLinks/PwCFinalReport.pdf> (last visited Feb. 12, 2004).

³⁶ HARRISINTERACTIVE INC., COMMON GOOD, COMMON GOOD FEAR OF LITIGATION STUDY: THE IMPACT ON MED. 65 (2002), available at http://ourcommongood.com/library/download/litrprt.pdf?item_id=10032 (last visited Feb. 12, 2004).

³⁷ *Id.* at 57. See also, Stuart Taylor & Evan Thomas, *Civil Wars*, NEWSWEEK, Dec. 15, 2003 (detailing America's increasingly litigious culture and its repercussions in the day to day work of physicians and other professionals).

³⁸ ADDRESSING THE NEW HEALTH CARE CRISIS, *supra* note 23.

³⁹ ROBERT BERENSON ET AL., CTR. FOR STUDYING HEALTH SYS. CHANGE., *Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places* (2003), available at <http://www.hschange.org/CONTENT/605/?words=malpractice> (last visited Feb. 3, 2004).

⁴⁰ DIV. OF MKT. RESEARCH & ANALYSIS, AM. MED. ASS'N, *supra* note 18.

⁴¹ BLUECROSS BLUESHIELD ASS'N, *supra* note 10, at 3.

6. Fear of medical liability suits is causing some emergency room physicians to order more hospitalizations and medical tests than other ER doctors.⁴²

G. Activity in the Crisis States

1. The September 2002 HHS update highlights rapid liability insurance rate escalation in states that have not established reasonable limits on unquantifiable and arbitrary non-economic damage awards. The government's report states that:

... 2001 premium increases in states without litigation reform ranged from 30%-75%. In 2002, the situation has deteriorated. **States without reasonable limits on non-economic damages have experienced the largest increases by far, with increases of between 36%-113% in 2002.** States with reasonable limits on non-economic damages have not experienced the same rate spiking. (emphasis added)⁴³
2. The Current Liability Crisis: The Crisis States⁴⁴
 - a. The AMA has identified the following twenty states currently experiencing a medical liability crisis: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, Nevada, West Virginia, and Wyoming.
 - b. Twenty-four states and the District of Columbia are seeing the warning signs of a potential crisis.
 - c. Only six states are considered stable: California, Colorado, New Mexico, Louisiana, Wisconsin, and Indiana.⁴⁵
 - d. As the result of reforms passed in 2003, including passage of a constitutional amendment and a strong cap on non-economic damages, Texas is now considered a state with effective reforms halting the crisis.
3. A Blue Cross/Blue Shield Association study concludes that the "medical malpractice insurance crisis is threatening healthcare affordability and access to care." (88% of plans agree.)⁴⁶

⁴² *Malpractice Fears Guide Behavior Of Some ER Physicians, Study Says*, HEALTH CARE DAILY, July 13, 2005.

⁴³ OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., SPECIAL UPDATE ON MED. LIABILITY CRISIS (2002), available at <http://aspe.hhs.gov/daltcp/reports/mlupd1.htm> (last visited Feb. 3, 2004).

⁴⁴ See AM. MED. ASS'N, AM.'S MED. LIABILITY CRISIS: A NAT'L VIEW, available at http://www.ama-assn.org/ama1/pub/upload/mm/-1/med_liab_19stat.pdf (last visited June 10, 2005).

⁴⁵ *Id.*

- a. Blue Cross/Blue Shield recognizes the AMA designation of “crisis” states and acknowledges the impending problems of 30 other states.⁴⁷
- b. The Blue Cross/Blue Shield study validates the conclusion that reduced access to care is a result of the current medical liability crisis.
 - i. Fifty-six percent (56%) of Blue Cross/Blue Shield plans in crisis states respond that physicians are refusing some high risk procedures. (In non-crisis states only 32% of plans report this finding.)⁴⁸
 - ii. Fifty-six percent (56%) of Blue Cross/Blue Shield plans in crisis states report that more physicians are leaving practice or retiring than in the past. (The response in non-crisis states is only 42%.)⁴⁹
 - iii. Almost 1/3 of the Blue Cross/Blue Shield plans in crisis states report that physicians are moving practices out of state. (In non-crisis states, only 1/5 of plans report that physicians are moving out of state.)⁵⁰

4. Selected Examples of Patients Losing Access to Care in the 20 Medical Liability Crisis States

View a map of crisis states at: <http://www.ama-assn.org/ama/noindex/category/11871.html>

(The following information is derived directly from the American Medical Association’s Medical Liability Crisis State Backgrounders, unless otherwise indicated.)

a. **Arkansas**

- i. Several physicians have discontinued their nursing home practice because of increased exposure and/or lack of insurance coverage for the nursing homes. Currently, there are no carriers writing new nursing home coverage. Those that have coverage have seen their premiums go up 1000% or more. Many nursing homes have been forced to “go bare: because of unaffordability or unavailability. (Arkansas Medical Society, March 2003)

⁴⁶ BLUECROSS BLUESHIELD ASS’N, *supra* note 10, at 2.

⁴⁷ *Id.*

⁴⁸ *Id.* at 9.

⁴⁹ *Id.*

⁵⁰ *Id.*

- ii. A 13-physician group of obstetricians at Fayetteville's FirstCare Family Doctors was forced to stop delivering babies after the group's primary insurer left the state and affordable insurance was not available. "This situation has totally disrupted the way of life we love here," said Sara McBee, MD. (Arkansas Business, January 13, 2003)
- iii. More than 50 percent of physicians surveyed reported they've been forced to reduce or discontinue one or more medical services in the last two years due to rising liability insurance premiums. "Surgery and other procedures" was cited as the most common service cut, followed by emergency-room care, "treating patients at nursing homes," on-call duty and obstetrics. (Information obtained from the Arkansas Medical Society, March 2003)
- iv. Medical liability reforms enacted in Arkansas in 2003 have come under fire with trial attorneys filing a lawsuit challenging the constitutionality of the new law.

b. Connecticut

- i. Experienced Ob-Gyn and teacher Dr. Benson Horowitz is so disgusted with the system that he fears giving advice to new obstetricians because that might implicate him in a future medical liability lawsuit. "It's almost like you've been a beneficiary of knowledge, but you can't be a benefactor," he said. (Associated Press, May 11, 2004)
- ii. Dr. Dickerman Hollister, an oncologist and former chief of staff at Greenwich Hospital, said fewer physicians means less access for patients. "It has reached a point where physicians cannot provide services and access to patients," he said. "What's going to happen is that people are going to lose the ability to see the physician of their choice." Hollister said female obstetricians and gynecologists are especially impacted. Many of those women work part time to mind their own children, he said, but since they must still pay full insurance premiums, they are forced to close their practices. "That's the canary in the coal mine," Hollister said. (Greenwich Time, April 24, 2004)
- iii. After two decades, Dr. Jeffery Lane has decided he can no longer afford to deliver babies and will refer as many as 30 current patients to other physicians when he drops Ob as of July 1, 2004, because of skyrocketing insurance premiums. "I really feel for my patients, who I've had to tell I won't be delivering them because they're due after my July first deadline." Dr. Lane said that it takes nearly forty deliveries to pay

for his insurance, but since he only delivers seventy-five babies a year, he's had to use personal savings to pay the insurance premiums. (WFSB, CT, May 9, 2004)

c. Florida

- i. More than 1,600 doctors from across Florida gave sworn statements to a state Senate panel in August 2003 detailing how the state's medical liability crisis forced them to change their practices, including no longer providing services such as delivering babies and performing complex surgeries. (Florida Medical Association)
- ii. Several neurosurgeons have left Palm Beach County and others have scaled back their practices because of concerns that emergency cases put them at higher risk for medical liability lawsuits. Only four neurosurgeons now handle emergency calls at the 13 hospitals in the county, increasingly leaving ERs with no one available, especially in the middle of the night and on weekends, health officials said. (Sun-Sentinel, March 13, 2004)
- iii. Patients from as far north as Palm Beach Gardens and as far west as Wellington routinely are being transported to hospitals in Broward and Miami-Dade counties, and sometimes to hospitals in central and northern Florida for emergency neurosurgical care, doctors and hospital officials said. Additional specialists cutting back emergency room coverage include hand surgeons, ophthalmologists and plastic surgeons. (Palm Beach Post, March 6, 2004)
- iv. At least seven Florida hospitals have closed their obstetrics units due to insurance concerns, and four other hospitals have reduced or limited obstetrics services. In addition, ten hospitals have eliminated, reduced or limited neurosurgical services. (Florida Hospital Association, January 2, 2003)
- v. More than half of 781 rural Florida doctors surveyed in late 2004 indicated that they had cut back on risky procedures. Childbirth was the procedure most likely to be reduced or stopped entirely; surgeries and emergency room procedures followed. (St. Petersburg Times, November 9, 2004)

d. Georgia

- i. Gainesville Ob-Gyn Linda Harrell, 49, learned in November that her insurance premiums had more than doubled in two years and she's now contemplating retirement. "How can you budget for increases like that?" Harrell asked. "I wanted to retire on my own terms. I didn't want to be run out." (The Atlanta Journal-Constitution, February 8, 2004)

- ii. General surgeon Bradley Carmen said that rising insurance costs are having a big impact in the medical profession, including at his hospital -- Marietta Memorial -- where he said four surgeons have moved out of state in the last year because of medical liability insurance costs. "It's difficult to get insurance even if we haven't had lawsuits before. We've been non-renewed twice for no reason and had 100 percent cost increases for insurance in the last couple of years. We really sit on pins and needles." (Marietta Times, April 15, 2004)
- iii. The Athens Women's clinic, which has offered obstetrics services for 35 years, announced May 21 that the state's medical liability crisis was forcing it to no longer deliver babies. It will continue to offer gynecological services. (Athens Banner-Herald, May 21, 2004)

e. **Illinois**

- i. The last two brain surgeons in Southern Illinois are leaving because of medical liability insurance premiums of nearly \$300,000 a year. Neurosurgeons B. Theo Mellion and Sumeer Lal of Neurological Associates of Southern Illinois turned in their resignations to Southern Illinois Healthcare, said Tom Firestone, chief executive officer of SIH, and will leave this summer. (UPI, February 25, 2004)
- ii. When three Ob-Gyns on staff at Advocate Lutheran General Hospital in Park Ridge learned their 2004 liability insurance premiums would climb from \$345,000 to \$510,470, they decided to take their practice to Kenosha, where during their first year their combined insurance will cost \$50,018. "This state is like the Titanic," said one of the doctors. "A year ago, we saw the iceberg. Now we've already hit." (Chicago Tribune, March 12, 2004)
- iii. Dr. Susan Hagnell grew up in Chicago's Rogers Park neighborhood, attended medical school in Illinois and delivered well over 700 babies at hospitals in the northwest suburbs. But when her liability insurance bill soared from \$71,848 to \$118,742 last summer, Hagnell decided to jump the border. Now she delivers Wisconsin babies. "If I knew what was going to happen, I would never have become an obstetrician/gynecologist." (Chicago Tribune, March 12, 2004)

f. **Kentucky**

- i. In the past three years, Kentucky has lost 36 percent of its practicing neurosurgeons, 29 percent of its general surgeons and 25 percent of its obstetricians, according to the Kentucky Medical Association. (Associated Press, January 13, 2004)
- ii. Pregnant women in eastern Kentucky will have a much more difficult time finding a doctor to deliver their babies since two hospitals that provided obstetrics -- Knox County in Barbourville and Our Lady of Bellefonte in Ashland -- have recently closed their doors, according to Dr. Joe Davis, an obstetrics and gynecological specialist in Bowling Green. "In the past few years, it's hit Kentucky significantly, especially in my specialty," said Dr. Davis. (Bowling Green Daily News, February 26, 2004; Kentucky Medical Association)
- iii. Kentucky's deteriorating practice environment continues to result in physicians leaving the state or retiring early. Between January 2000 and December 2002, the state has lost more than 1,200 physicians, nearly one-third to neighboring states and another one-third to early retirement. (Louisville Courier-Journal, November 11, 2003)

g. Massachusetts

- i. A 2004 Massachusetts Medical Society Workforce study found that high-risk specialists are limiting their scope of practice and altering how they practice, including practicing defensive medicine because of the fear of being sued. Among the high-risk specialists affected are:
 - 68 percent of emergency medicine specialists
 - 64 percent of neurosurgeons
 - 64 percent of Ob-Gyns
 (MMS 2004 Physician Workforce Study, April 2004)
- ii. Jane Confort, 52, is one of more than one dozen patients who had to be airlifted by helicopter to Boston from Saints Memorial Medical Center in Lowell since it had lost 24-hour neurosurgery coverage after two of six neurosurgeons in the region retired recently, and the facility's medical group had been unable to find replacements. Mrs. Confort was okay, and Dr. Gary DeLong, director of emergency room services at Saints Memorial in Lowell, said although he believes the shortage hasn't hurt the quality of patient care, "it has affected orderly, convenient patient care." But, he said, "when someone has an acute hemorrhage inside the brain, those patients need surgery quickly." (Boston Globe, April 28, 2004)

- iii. Some of Massachusetts' most experienced orthopedic surgeons say that it is growing more difficult to recruit new physicians. "I have been trying to recruit a partner for several years," said hand surgeon William Ericson, MD. "And no one wants to come to Massachusetts. My most hopeful prospect just informed me that he is leaving the state." R. Scott Oliver, MD, also has had difficulty recruiting and said that "in the last year, I've interviewed five young doctors for positions in my group practice, and all have turned to other opportunities." (Massachusetts Medical Society, September 18, 2003)
- iv. A study of voters conducted in mid-2004 found that nearly 70% favored limiting awards for non-economic damages. (The Boston Herald, June 8, 2004)

h. Mississippi

- i. Rural obstetric care is in serious jeopardy. Cleveland has lost three of six Ob-Gyns, Greenwood has lost two of four, and Yazoo City-with 14,550 residents, has no one practicing obstetrics. (Associated Press, November 19, 2003)
- ii. Fifty-one of Mississippi's 82 counties face doctor shortages, according to a report by the Mississippi Health Policy Research Center. Starkville physician Steve Parvin, president-elect of the Mississippi State Medical Association, said a major reason for Mississippi's depleting work force of physicians is the high cost and scarcity of medical liability insurance. (Health & Medicine Week, December 29, 2003)
- iii. Pediatric specialist Kurt Kooyer, MD, left the small town of Rolling Fork after getting fed up with a legal system that allowed lawyers to file suit against him without the patients knowledge they were suing their physician. Dr. Kooyer, the only pediatrician among three physicians in town, arrived in 1994 and was responsible for the infant mortality decreasing from an average of 10 deaths per 1,000 live births to 3.4. Dr. Kooyer now lives in North Dakota. (Clarion Ledger, August 23, 2003)
- iv. Donald Palmisano, MD, Immediate Past-President of the AMA recently learned from a young surgeon that he "understood the crisis all too well because he recently lost his son because there was no neurosurgeon available." Mississippi surgeon John Lucas, III, MD, related that his son was in a car accident and needed immediate neurosurgical intervention, but the area's neurosurgeons had already either quit doing head trauma cases or had moved away. His son had a correctible problem if immediate

attention by a neurosurgeon could be given. Dr. Lucas did everything he could to expedite the transfer and find a neurosurgeon. Unfortunately, the transfer came too late and his son John Lucas, IV died.

i. Missouri

- i. After obstetrician Jamie Ulbrich's liability insurance carrier stopped doing business in Missouri, the best coverage he and three colleagues at their Marshall clinic could find would have cost them double what they paid in 2003. The four doctors decided they couldn't each afford the \$50,000 liability insurance premium, so they decided to stop providing obstetric service and instead work solely as family physicians in 2004. (The Associated Press, January 3, 2004)
- ii. Dr. Scot Pringle, a Cape Girardeau obstetrician, said he has delivered approximately 8,000 babies during his 23 years, and his premiums will likely exceed \$85,000 if he continues to practice. "A lot of us have been practicing long enough we are near retirement," Dr. Pringle said. "Frankly, I don't want to put up with this mess anymore." (Southeast Missourian, April 26, 2004)
- iii. Dr. Donald Maples, a Kirksville family physician for 14 years, was forced to close his practice due to the high costs of medical liability insurance. "I am unbelievably saddened by this, this is not what I expected in my career, I expected to be here until I was in my mid-60s, but the reality is that I can no longer really truly afford to do this," said Maples, who will work as a full-time employee for Northeast Regional Medical Center. (KTVO, April 30, 2004)

j. North Carolina

- i. Dr. David Pagnanelli, a neurosurgeon, said he moved to Hendersonville, North Carolina in 2002 because liability costs were too high in Pennsylvania. But they shot up here too -- to nearly \$190,000 a year -- even though there've been no successful claims against him, he said. Following his insurance carrier's advice, Pagnanelli stopped seeing trauma cases. But neurosurgeons are in short supply in Hendersonville, so his decision means patients with life-threatening head injuries have been shipped to other hospitals. (Charlotte Observer, February 11, 2004)
- ii. "If we remain in North Carolina we will likely be forced to make the decision to limit procedures which carry high risks (but also are often life-saving)," said K. Stuart Lee, M.D. of Eastern Neurosurgical and

Spine Associates Inc. Dr. Lee's practice saw their medical liability premiums increase 116 percent last year. (The News and Observer, January 26, 2003)

- iii. Dr. Lew Stringer, the medical director for Forsyth County Emergency Medical Services for 30 years, resigned that position in 2003 because he could not find liability insurance coverage. "It's sad after all these years of helping citizens to be forced to resign for lack of adequate coverage," he said. "What other choice did I have?" (Winston-Salem Journal, June 3, 2003)

k. Nevada

- i. Mary Rasar's father died in Las Vegas after the only Level 1 trauma center was forced to close due to skyrocketing medical liability costs. Jim Lawson was injured July 4 in a traffic accident and rather than being rushed to the Level 1 trauma center at nearby University Medical Center, which had been forced to close, Lawson was taken to a hospital that did not have the resources necessary to save his life. He died while physicians tried to stabilize him for airlift to Salt Lake City. (PR Newswire, April 21, 2003)
- ii. Pregnant women continue to lose access to care as skyrocketing insurance premiums are forcing Ob-Gyns to stop delivering babies. Frieda Fleischer, MD, gave up obstetrics because her premiums rose from \$30,000 annually to \$80,000. "So far, I've had about 40 pregnant patients to refer elsewhere and it's been tough." Carolyn Faris, with the help of her former obstetrician, called more than 60 area doctors to find someone to deliver her baby. It wasn't until after experiencing pregnancy complications that Faris found a specialist to care for her. And Ruth Valentine, who was six months pregnant at the time, said she called more than 50 doctors and still could not find a local physician to deliver her baby, so she went to see an obstetrician in St. George, Utah. (Las Vegas Review-Journal, January 10, 2003)
- iii. "I left Nevada because the litigation climate had driven medical liability premiums to astronomical heights," Ob-Gyn Shelby Wilbourn, MD, testified before a Congressional subcommittee. Dr. Wilbourn, whose premiums increased to \$108,000, moved to Maine this year and still receives calls from some of the 8,000 patients he saw during his 12 years in Nevada. "Liability isn't about fault or bad practice-it's about hitting a jackpot. Even the best Ob-Gyns have been sued, many more than once." (Associated Press, February 12, 2003)

l. New Jersey

- i. One out of every four hospitals-nearly 27 percent-has been forced to increase payments to find physicians willing to cover the emergency department. Physicians are increasingly reluctant to take on such assignments because of the greater liability exposure. (New Jersey Hospital Association, January 28, 2003)
- ii. Numerous obstetricians and other physicians from several New Jersey counties have been forced to restrict their practices, consider early retirement or leave the state altogether, due to unaffordable premiums. Affected counties include: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union and Warren. (Medical Society of New Jersey Alliance)
- iii. Dr. Stephen Smith says that part of the reason costs are going up is the doctors are now forced to practice defensive medicine. "What bothers me so much is that element of -- of fear and doubt that is created by this system we're in. What we're doing now is we practice [cover your ass] medicine. His father, also a physician, is worried that the legal climate could cause a future shortage of high-risk specialists: "the best students are not going into high-risk fields, they're not going into OB, they're not going to neurosurgery." (60 Minutes, March 9, 2003)

m. New York

- i. Many young doctors won't specialize in obstetrics. They fear the threat of lawsuits and wince at liability insurance costs, which can be as much as \$200,000 per year. Last summer, Manhattan's Elizabeth Seton Childbearing Center, which practiced natural childbirth, had to close when its medical liability insurance premiums rocketed to \$2 million. (New York Daily News, February 12, 2004).
- ii. The Niagara Falls area now has only seven obstetricians, down from 13 in 1981 in a decline that far outpaces the area's population decrease. One of the remaining obstetricians, Dr. David Zornek, cites the liability premium and constant threat of economically-disastrous lawsuits as precipitating factors. "I could lose everything I've worked for," he worries. (Buffalo News, April 27, 2003)
- iii. Dr. John Cafaro, 45, an Ob-Gyn in Garden City, said some doctors are paying \$130,000 for only \$1 million worth of protection. "But we are getting sued for \$85 and \$90 million at a time," he said. "You do the math. Every time I walk into an operating room I put my

family's life savings on the line." (New York Times, May 25, 2003)

n. **Ohio**

- i. "My wife and I are both physicians and just arrived in Wausau [Wisconsin] in March. We fled the crisis in Ohio after spending our whole careers in that state," said Christopher J. Magiera, a gastroenterologist. Magiera and his wife, Pamela G. Galloway, a general surgeon, gave up their 15-year-old practice when their medical liability premiums were projected to reach \$100,000 apiece. In Wisconsin, they pay a fraction of that. (Journal Sentinel, April 20, 2003)
- ii. Dr. Rebecca Glaser, a popular breast cancer specialist, will retire from surgery on April 1 because of high liability insurance premiums. "I think it's horrifying when we lose a physician who has literally a one-of-a-kind practice," said Donna Buchheit, one of Glaser's breast cancer patients. She continues, "It is literally a life and death issue. The legislature needs to understand that. It is not melodramatic to say that there will be women who die this year because of this. I certainly hope I won't become one of them." (Dayton Daily News, February 28, 2004)
- iii. Dr. Daniel Guyton, chief of surgery at Akron General Medical Center, said the anecdotal evidence is overwhelming on how many doctors are being forced out of business or out of state by the cost of insurance. "It's getting to the point you can't recruit people [to Ohio]." (Akron Beacon Journal, March 14, 2004)

o. **Oregon**

- i. 43.4% of Oregon neurosurgeons, 27.1% of orthopedic surgeons, and 23.5% of Ob-Gyns reported they have already stopped providing certain services or would do so. Among all physicians, those in NW Oregon (9.7%), SW Oregon (10.6%) and E Oregon (13.2%) have stopped providing direct patient care or will do so. (Oregon Medical Association, April 2003)
- ii. Dr. Katherine Merrill delivered as many as 40 babies a year in Astoria, a job she loved. In August 2003, Merrill stopped delivering babies -- a decision prompted by the steeply rising costs of medical liability insurance. Merrill said something needs to be done to keep physicians from leaving the state or quitting high-risk specialties. "Otherwise there will be no doctors in your town to deliver babies or to do brain surgery when you've been in a car accident," she said. (The Associated Press, January 24, 2004)

- iii. Rural patients in Oregon are being particularly hard hit. Roseburg Women's Healthcare, which delivered 80% of the babies for the area, closed its doors in May 2002 because its liability insurance was canceled after a single, \$8.5 million lawsuit. The closest other providers are 60-90 minutes away. "We consider this a medical crisis for the community," Mercy Medical CEO Vic Fresolone told the Associated Press. (June 26, 2002)

p. Pennsylvania

- i. Young Ob-Gyn Dr. Christine Larson decided to move her family to Minnesota and start over because of Pennsylvania's worsening medical liability crisis. Dr. Daniel Kegel, president of OB-GYN of Lancaster -- Dr. Larson's former group -- said "most (young doctors) are going to make the same decision (to leave Pennsylvania)." Dr. Kegel emphasized that losing a young doctor "exacerbates the difficulty we have with a limited number of appointment slots and an increasing demand for them. It is difficult to accommodate everyone who wants and needs us." (Lancaster Sunday News, September 14, 2003)
- ii. More than two out of three medical residents in six medical specialties chose to leave Pennsylvania after completing their training, according to the Philadelphia Daily News, which examined data from the city's major teaching hospitals between 1998-2002. "The resident brain drain is greatest among doctors going into high-risk specialties: Ob-Gyns, orthopedic surgeons and neurosurgeons. These doctors, not surprisingly, are most likely to be sued for malpractice -- and pay some of the highest malpractice insurance premiums." (Philadelphia Daily News, May 28, 2003)
- iii. According to Grand View Hospital President Stuart Fine, the medical liability crisis is a main reason why patient access problems are occurring throughout the state and "has caused experienced doctors to leave the area, especially neurosurgeons, orthopedic and general surgeons, obstetricians and cardiologists. Few young doctors are coming in to take their place, and the result is a shortage of doctors." (Morning Call (Allentown, PA), January 23, 2004)

q. Rhode Island

- i. Dr. Kate Cassin, an ob-gyn stopped practicing obstetrics after her annual premium went from \$28,000 in 2000 to \$90,000 in 2004 -- even though she had never been sued. (The Providence Journal , June 8, 2004)

- ii. Minoj Garg, DO, stopped delivering babies in July 2004 at his Pawtucket practice due to the high costs of liability insurance associated with obstetrical care. He was the last family physician in private practice to deliver babies in Rhode Island. (Rhode Island Medical Society)

r. **Washington**

- i. Delivering babies finally got too expensive for Mount Vernon doctor Bob Pringle. Like many physicians throughout Washington, he has abandoned obstetrics. "Patients who find themselves in high-risk pregnancies are going to have a problem," he said of the trend. Pringle, who recently cut his practice to part-time gynecology, said delivering babies would cost him \$79,000 a year in liability insurance, nearly twice what it did a few years ago. (Seattle Post-Intelligencer, March 3, 2004)
- ii. When rural doctors decide to drop obstetrics insurance coverage and stop delivering babies because of liability insurance premiums -- as they have in Odessa, Republic and Davenport -- they're also prohibited by their insurance companies from offering prenatal care. That means more pregnant women who've never had a prenatal check-up are showing up at Spokane hospitals to deliver babies. "That is Third-World medicine," said Tom Corley, president of Holy Family Hospital. "That's what you'd expect in the middle of Africa." Other rural women are making long drives into Spokane for prenatal care. (The Spokesman-Review, March 2, 2004)
- iii. Facing escalating liability insurance rates, Valley Women's Healthcare, one of the larger obstetric and gynecology clinics in south King County, is reducing services. Swedish Physicians, which operates out of 11 clinics including Pine Lake and Factoria, has cut the number of family physicians delivering babies from 21 to 7. (King County Journal, January 25, 2004)

s. **West Virginia**

- i. A January 2003 American College of Obstetricians & Gynecologists survey found:
 - 80% of doctors responding knew that women were having trouble obtaining Ob-Gyn services;
 - 83% were aware that West Virginia hospitals were having trouble recruiting Ob-Gyns; and
 - 47% knew Ob-Gyns who changed their specialty or practice because of liability concerns.
- ii. Ashton Medical said it no longer will accept walk-in patients at the clinic in Ashton Place shopping center. Because the amount the doctors pay for medical

liability insurance through the state Board of Risk and Insurance Management has increased significantly, they had to lay off five employees and cut hours. (Charleston Daily Mail, April 2, 2004)

- iii. A recent survey found that 94 percent of West Virginia doctors have changed the way they practice medicine because of litigation concerns. The survey also found that 97 percent of state doctors believe medical liability lawsuits drive up the cost of patient care. (American Tort Reform Association, March 2004)

t. **Wyoming**

- i. Some Wyoming physicians are moving to Colorado or will soon do so. Colorado is a state with strong reforms and has a stable liability insurance market. Two examples:

1. Jim Derrisaw, MD, a Riverton anesthesiologist, moved his young family to Ft. Collins, Colorado to practice. Dr. Derrisaw grew up in Cheyenne, graduated from the University of Wyoming, married a native of Encampment, and returned to Wyoming to raise his family and "practice medicine in the state I love." Student loan debt for medical school of more than \$100,000, coupled with insurance premiums that had escalated to \$52,000 per year, created a burden that his deep Wyoming roots could not overcome. His insurance coverage in Colorado, a state with caps on non-economic damages and other key liability reform measures, has been quoted at a cost of \$8,200.
2. Cheyenne urologist Stacy Childs, MD will end his practice in Wyoming on May 31, 2004, and move to Colorado, where his liability insurance premiums will be considerably less. Dr. Childs was an advocate for patients and physicians and served as Chairman of the WMS Liability Reform Task Force in 2003. He also served the people of the state during his tenure on the Wyoming Health Care Commission. (Wyoming Medical Society)

II. Solutions

- A. Studies and Expert Opinions Confirm that Certain Types of Reform Lower Costs and Improve Access

1. Viscusi and Born (2005) examined the impact of tort reforms enacted in the mid to late 1980s on medical liability premium revenues and incurred losses.⁵¹ They found that insurers in states that enacted caps on non-economic damages had losses 17% lower than those of insurers in other states. Earned premiums were 6% lower. In addition, they found that losses and premiums of insurers in states where punitive damages were not allowed were 16% and 8% lower, respectively, than losses and premiums of insurers in states that allowed punitive damages. Caps on punitive damages had, predictably, smaller impacts than the prohibition of punitive damages, only 7% on losses and no impact on premiums.
2. Thorpe's work (2004) was similar to that of Viscusi and Born (2005).⁵² Thorpe found that premium revenue was between 13% and 17% lower in states that capped non-economic or total damages than in states that did not. Unlike Viscusi and Born (2005), he did not find that premium revenue was affected by limitations on punitive damages.
3. Zuckerman, Bovbjerg, and Sloan (1990) estimated the impact of a variety of tort reforms on premiums and claim severity.⁵³ The base-rate premium data and average (per-claim) indemnity data were for 1975 through 1986 and from separate surveys of insurers. The authors found that capping physician liability (but not caps on non-economic damages) reduced premiums for general surgeons by 13% in the year following enactment of that reform and by 34% over the long term. The impact on premiums paid by general practitioners and obstetricians and gynecologists were similar. Looking at physicians across all specialties, they found that caps on non-economic damages (but not caps on physician liability) decreased the average indemnity per paid claim (claim severity). The authors were not able to resolve the different impacts that caps on physician liability and caps on non-economic damages had on premiums and losses.

⁵¹ W. Kip Viscusi and Patricia H. Born, *Damage Caps, Insurability, and The Performance of Medical Malpractice Insurance*, THE J. OF RISK AND INS., Mar. 2005, at 23-43.

⁵² Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends And The Impact Of State Tort Reforms*, HEALTH AFFAIRS, Jan. 21, 2004, at W4-20-W4-30.

⁵³ Stephen Zuckerman, Randall R. Bovbjerg, and Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, INQUIRY, Summer 1990, at 167-182.

4. Sloan, Mergenhagen, and Bovbjerg (1989) looked at the impact of tort reform using closed claim data for 1975 through 1978 and for 1984.⁵⁴ The authors found that caps on non-economic damages reduced insurer payouts by 31% and reduced payouts-plus-expenses by 23%. The impacts of caps on total damages were somewhat larger, 38% and 39%, respectively.
5. Kessler and McClellan (1996) compared hospital expenditures on Medicare beneficiaries with heart disease in states with direct, indirect, and no tort reforms.⁵⁵ Direct reforms include but are not limited to caps on non-economic damages. They concluded that states adopting direct reforms in the late 1980s exhibited reductions in hospital expenditures of 5% to 9% within three to five years without substantial adverse affects on mortality or complications. Because outcomes were not affected, they attributed the cost difference to defensive medicine. If their results are applied to all medical spending, this would have amounted to an \$83.9 to \$151.1 billion reduction in national health spending in 2003.
6. Kessler and McClellan (1997) examined “malpractice pressure,” measured by liability premiums and claim frequency, and how that pressure was affected by tort reform.⁵⁶ Both the premium and frequency data were from 1985 through 1993 surveys of physicians conducted by the AMA. They found that direct reforms reduced premiums by 8.4% within the first three years after a reform, and reduced the likelihood that a physician would be sued by 2.1%. A number of literature reviews have also concluded that caps on non-economic damages work to reduce claim severity and premiums.
7. Using a variety of data sources, Hamm, Wazzan, and Frech (2005) concluded that MICRA has led to a reduction in medical liability costs both through a reduction in the filing of weak claims and a reduction in the severity of paid claims.⁵⁷ After comparing claim frequency in California to that in other states they also concluded that MICRA did not reduce access to the courts.
8. The Congressional Budget Office (1998) concluded that caps on non-economic damages were one of two reforms that “have been found extremely effective in reducing the amount of claims paid

⁵⁴ Frank A. Sloan, Paul M. Mergenhagen, and Randall R. Bovbjerg, *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: a Microanalysis*, J. OF HEALTH POLITICS, POLICY AND LAW, 663, 663-669 (1989).

⁵⁵ Daniel Kessler and Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 445 Q. J. OF ECON. 353, 353-390 (1996).

⁵⁶ Daniel P. Kessler and Mark. B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, LAW AND CONTEMPORARY PROBS., Winter 1997, at 81-106.

⁵⁷ WILLIAM G. HAMM, C. PAUL WAZZAN AND H.E. FRECH, III, *MICRA AND ACCESS TO HEALTHCARE* (2005), available at <http://www.micra.org/MICRAStudy22805.pdf> (last accessed on Oct. 18, 2005).

and medical liability premiums.”⁵⁸ The other reform was collateral source offset provisions.

9. The Office of Technology Assessment (1993) concluded that “caps on damage awards were the only type of State tort reform that consistently showed significant results in reducing the malpractice cost indicators.”⁵⁹
10. Kessler, Sage, and Becker (2005) examined physician supply using annual data for the period from 1985 through 2001.⁶⁰ They found that direct tort reforms increased physician supply by 2.4% relative to non-reform states. They also looked at the impact on a number of high-risk specialties and found that the impact on emergency physicians was particularly large, 11.5%.
11. Encinosa and Hellinger’s paper (2005) was similar.⁶¹ It, however, looked specifically at the impact of caps on non-economic damages, and included only eight years of data from 1985 through 2000. Their results suggest that caps increased the number of physicians per capita by 2.2% relative to states without caps.

B. State Efforts to Enact Caps on Non-Economic Damages

1. Twenty-five states have enacted a cap on non-economic damages, while six states have a cap on total damages. Colorado places a cap on total damages and non-economic damages.
 - a. States with a cap on non-economic damages – Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Kansas, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia, and Wisconsin.

⁵⁸ CONG. BUDGET OFFICE, PRELIMINARY COST ESTIMATE, H.R. 4250, PATIENT PROTECTION ACT OF 1998 (1998), available at <http://www.cbo.gov/ftpdocs/7xx/doc701/hr4250.pdf> (last accessed on Oct. 18, 2005).

⁵⁹ OFFICE OF THE TECH. ASSESSMENT, IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS, OTA-BP-H-119 (1993), available at <http://www.wwww.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1993/9329/9329.pdf> (last accessed on Oct. 18, 2005). The OTA was nonpartisan analytical agency that provided assistance to the U.S. Congress for 23 years through 1995.

⁶⁰ Daniel P. Kessler, William M. Sage, and David J. Becker, *Impact of Malpractice Reforms on the Supply of Physician Services*, 293 JAMA 2618-2625 (2005).

⁶¹ William E. Encinosa and Fred J. Hellinger, *Have State Caps On Malpractice Awards Increased The Supply Of Physicians?*, HEALTH AFFAIRS, May 31, 2005, at W5-250-W5-W258, available at <http://content.healthaffairs.org/contents-by-date.0.shtml> (last accessed on July 7, 2005).

- b. States with a cap on total damages – Colorado, Indiana, Louisiana, Nebraska, New Mexico, and Virginia.

- 2. A cap's effectiveness depends on the specific provisions of the legislation with which it was enacted.

For example, a state with a “hard” cap on non-economic damages should not be compared to a state with a “soft” cap on non-economic damages. A hard cap, like the \$250,000 cap found in California’s MICRA is not subject to exceptions, does not adjust over time, and applies irrespective of the number of defendants or plaintiffs. By contrast, a “soft” cap may be subject to numerous exceptions; increase annually with inflation, other economic indicators, or based on a set schedule; or apply individually to every defendant or plaintiff, thereby allowing several caps for a single claim.

- a. Examples of states with a soft cap

- i. Florida – Florida has a separate cap on non-economic damages for practitioners (\$500,000) and non-practitioners (\$750,000). The cap, however, increases to \$1 million for practitioners and \$1.5 million for non-practitioners if the negligence results in death or a permanent vegetative state or if the court finds a manifest injustice would occur if the cap was not increased.
- ii. Massachusetts – The \$500,000 cap on non-economic damages in Massachusetts does not apply if the court finds the patient’s injury resulted in substantial disfigurement or permanent loss or impairment, or if the court determines that other special circumstances warrant a finding that such limitation would deprive the plaintiff of just compensation for the injuries sustained.
- iii. Missouri – Missouri enacted a new law in 2005 which considerably strengthened their previous cap and established a hard \$350,000 cap on non-economic damages (see paragraph 3.h. of this section for more information). Missouri’s previous cap had increased with inflation. Originally set at \$350,000 in 1986, the cap reached \$565,000 on February 1, 2004.⁶² In addition, the cap applied individually to each defendant and each plaintiff. The courts also considerably weakened the cap in a 2002 decision, Scott v. SSM Healthcare, in which the court held that the cap could be applied separately for each act of

⁶² MO. REV. STAT. § 538.210 (2004).

medical liability. Therefore, if there were two separate and distinct “occurrences” of liability that contributed to a single injury the court could apply a separate cap for each occurrence even against a single defendant.⁶³

- b. Recognizing the ineffectiveness of a soft cap, several states, such as Alaska, Mississippi, and Missouri have recently enacted legislation to strengthen their cap. Likewise, Nevada voters adopted a ballot initiative in 2004 to replace a cap riddled with exceptions with a hard \$350,000 cap on non-economic damages.
 - c. A cap on non-economic damages that is set too high will also not be as effective as a \$250,000 hard cap like California. For example, prior to enacting legislation in 2003, West Virginia had a \$1 million cap on non-economic damages. At this high level the cap was ineffective.
3. Recent State Legislation Enacting Caps on Non-Economic Damages (See next section, 4. Election 2004 Ballot Measures for supplemental information on Florida, Nevada, Oregon and Wyoming)
- a. Alaska
 - i. Signed into law by Governor Murkowski on June 7, 2005, S.B. 67 strengthens Alaska’s existing cap on non-economic damages by establishing a \$250,000 cap on non-economic damages awarded in a personal injury cause of action, and a \$400,000 cap on non-economic damages awarded in a cause of action involving wrongful death or a severe permanent physical impairment that is more than seventy percent disabling. A single cap applies regardless of the number of health care providers against whom the claim is asserted or the number of causes of action filed.
 - b. Florida
 - i. After four special sessions, Florida’s legislature enacted S.B. 2-D, which was signed into law by Governor Jeb Bush on August, 14, 2003. In its final form, the bill does not provide the level of reforms advocated by Governor Bush’s task force or by the Florida Medical Association (FMA). In particular, the language on non-economic damages and exceptions to the cap added during late stages of negotiations are

⁶³ Scott v. SSM Healthcare, 70 S.W.3d 560, 569, 571 (Mo. Ct. App. 2002), *aff’d* Cook v. Newman, No. WD62634 (Mo. Ct. App. 2004).

troublesome. In fact, this clause prohibited FMA from supporting the legislation in its final form.⁶⁴

- ii. S.B.2-D provides a separate cap on non-economic damages for practitioners and non-practitioners. For practitioners, the cap is \$500,000 per claimant regardless of the number of defendants. For non-practitioners, the cap is \$750,000 per claimant regardless of the number of defendants. The cap can increase to \$1 million for practitioners and \$1.5 million for non-practitioners if the negligence resulted in death or a permanent vegetative state, or if the court finds a manifest injustice would occur if the cap was not increased because the non-economic harm sustained by the patient was particularly severe and the defendant's negligence caused a catastrophic injury to the patient. While physicians' insurance rate growth in Florida averaged 8% in 2005, and 5% in 2004, after double-digit increases in the four preceding years, only a small portion of the leveling-off was attributable to the caps after adjustment for other factors (e.g., an overestimation of the number of Florida physicians with \$1 million dollar coverage policies, a moderation of losses and the effect of prior years' rate increases).⁶⁵

c. Georgia

- i. On February 16, 2005, Governor Purdue signed into law S.B. 3. As enacted, S.B. 3 creates a Texas-style cap on non-economic damages. The new law establishes a hard \$350,000 cap on non-economic damages awarded in a medical liability action, including wrongful death, against all health care providers and a separate \$350,000 cap on non-economic damages awarded against a single medical facility that can increase to \$700,000 if more than one facility is involved. No more than \$1.05 million can be awarded in a medical liability cause of action. The caps apply to each claimant, however, the term "claimant" is defined in the law as including all persons claiming to have sustained damages as a result of the bodily injury or death of a single person.

d. Idaho

- i. On March 26, 2003, Governor Kempthorne signed into law H.B. 92 which includes a \$250,000 cap on non-economic damages (Idaho previously had a \$400,000 cap on non-economic damages which adjusted annually for inflation since 1988). The new cap also adjusts annually for inflation based on the average

⁶⁴ FLA. STAT. ch. 766.118 (2004).

⁶⁵ Brian Bandell, *Doctors finally get single digit insurance hikes*, BIZJOURNALS, June 13, 2005.

annual wage beginning July 1, 2004. The cap does not apply to causes of action arising out of willful or reckless misconduct, or felonious actions.⁶⁶

e. Illinois

- i. On August 25, Illinois' Governor Blagojevich signed into law a medical liability reform bill that included a \$500,000 cap on non-economic damages for awards in a medical liability cause of action, including wrongful death, against a physician, the physician's business or corporate entity, and personnel or health care professionals. The new law also establishes a separate \$1 million cap on non-economic damages for awards in a medical liability cause of action, including wrongful death, against a hospital and its personnel or hospital affiliates. Both caps apply to all plaintiffs in any civil action arising out of the care. The caps apply to injuries that occur after the effective date of the act.⁶⁷

f. Iowa

- i. Governor Vilsack vetoed H.F. 2440⁶⁸ on May 14, 2004, which would have provided a \$250,000 cap on non-economic damages for awards against a health care provider in a medical liability cause of action.

g. Maryland

- i. Enacted in January 2005, Maryland's H.B. 2 (2004) establishes a separate cap on non-economic damages for personal injury and wrongful death suits involving two or more claimants or beneficiaries. Non-economic damages awarded against a physician for personal injury, are capped at \$650,000 until January 1, 2009, after which time the cap will increase \$15,000 each year. The cap applies in aggregate to all claims and defendants arising from the same medical injury. (Cap also applies in wrongful death actions if the claim involves only one claimant or beneficiary). For wrongful death claims involving two or more claimants or beneficiaries, the total cap on non-economic damages is \$812,500 (i.e., 125% of the current \$650,000 non-economic damages cap in PI claims).

h. Mississippi

On June 3, 2004, the Mississippi Legislature enacted H.B. 13 a civil justice reform bill that further

⁶⁶ ID. REV. STAT. § 6-1603 (2004).

⁶⁷ S.B. 475, 2005 Leg., 93rd Sess. (II. 2005).

⁶⁸ H.F. 2440, 80th Gen. Assem., Reg. Sess. (Ia. 2004)

strengthens Mississippi's medical liability reform laws. Most importantly the bill creates a hard \$500,000 cap on non-economic damages for medical liability causes of action filed against a health care provider. This provision significantly strengthens Mississippi's existing cap, which was enacted into law in 2002, by deleting the exceptions to the cap and increases that were scheduled to occur in 2011 and 2017.⁶⁹

i. Missouri

- i. On March 29, Governor Blunt signed into law H.B. 393, which among other medical liability reforms, includes language strengthening Missouri's cap on non-economic damages. With passage of H.B. 393, Missouri now has a hard \$350,000 cap on non-economic damages. H.B. 393 deletes language in Missouri's law that adjusted the cap annually and deletes the word "occurrence" from the law, thereby clarifying that multiple caps cannot apply to a single defendant (effectively overturning the *Scott* decision in which the Missouri Supreme Court interpreted the term "per occurrence" to apply to each individual act of negligence even if multiple caps could apply to a single defendant). H.B. 393 also specifies that a single \$350,000 cap will apply irrespective of the number of defendants.

j. Nevada

- i. Cap on non-economic damages. As the result of passage of the Keep Our Doctors in Nevada initiative in 2004, Nevada has a \$350,000 cap on non-economic damages in medical liability cases.⁷⁰
- ii. Cap on trauma care. In August 2002, Nevada enacted A.B. 1 which in part establishes a \$50,000 cap on civil damages for claims arising from care necessitated by a traumatic event demanding immediate attention that is rendered in good faith to a patient who enters the hospital through the emergency room or trauma center. This limit does not apply to any act or omission in rendering care or assistance that occurs after the patient is stabilized (unless surgery is required within a reasonable time after the patient is stabilized) or that is unrelated to the original traumatic injury.

In cases where the physician or dentist provides follow-up care to the patient they treated in the above circumstances and the patient files a medical liability

⁶⁹ H.B. 13, Miss. Gen. Assem. 1st Extraordinary Sess. (2004).

⁷⁰ NEV. REV. STAT. § 41A.031 (2004).

claim based on a medical condition that arises during follow-up care, a rebuttable presumption exists that the medical condition was the result of the original traumatic injury and the \$50,000 limit applies.

This limit does not apply in cases amounting to gross negligence or reckless, willful or wanton conduct.⁷¹

k. Ohio

- i. On January 10, 2003, Ohio Governor Taft signed into law S.B. 281, a medical liability reform bill to address the growing crisis in Ohio. Among other provisions, the bill establishes a sliding cap on non-economic damages. The cap shall not exceed the greater of \$250,000 or three times the plaintiff's economic loss up to a maximum of \$350,000 for each plaintiff or \$500,000 per occurrence. The maximum cap will increase to \$500,000 per plaintiff or \$1,000,000 per occurrence for a claim based on either (A) a permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or (B) a permanent physical functional injury that permanently prevents the injured person from being able to independently care for oneself and perform life sustaining activities.⁷²

l. Oklahoma

- i. On May 28, 2004, Governor Brad Henry signed into law a civil justice reform bill (H.B. 2661). The bill maintains the existing cap on non-economic damages for obstetrics and emergency room care, which was enacted in 2003, and establishes a \$300,000 cap on non-economic damages for all other medical liability causes of action. The cap applies only if the defendant has made an offer of judgment and the amount of the verdict awarded to the plaintiff is 1 ½ times the amount of the final offer of judgment. The cap applies to each medical injury regardless of the number of actions brought and adjusts annually based on any increases in the Consumer Price Index. The cap does not apply if the jury finds by a preponderance of the evidence that the defendant's conduct was willful or wanton or by clear and convincing evidence that the defendant committed negligence. Before these questions can be presented to the jury, the judge must first determine there is enough evidence to establish these findings. The cap does not apply in cases

⁷¹ *Id.* at § 41.503.

⁷² OHIO REV. CODE § 2323.43 (2004).

involving wrongful death as this is prohibited by Oklahoma's Constitution.⁷³

- ii. On June 4, 2003, Oklahoma's Governor Henry signed into law S.B. 629. Among other provisions, S.B. 629 includes a \$300,000 cap on non-economic damages for cases involving pregnancy, labor and delivery, or care provided immediately post-partum. The cap also applies in cases involving emergency-room care or medical services provided as a follow up to such care. The bill allows a judge to lift the cap if the judge makes a finding that there is clear and convincing evidence of negligence. The cap applies regardless of the number of parties against whom the medical negligence action is brought. The \$300,000 damage limit does not apply in wrongful death cases. The cap provision is scheduled to sunset in 5 years.⁷⁴

m. Pennsylvania

- i. In December 2003, Pennsylvania's legislature enacted H.B. 44, which establishes the Health Care Provider Retention Program. H.B. 44 provides physicians a full or partial abatement of their MCARE assessments for 2003 and 2004. A health care provider can receive a full abatement of the assessment if he/she meets one of the following criteria: is assessed as a member of one of the four highest rate classes of the prevailing primary premium, is an emergency physician, routinely provides obstetrical services in a rural area, or is a certified nurse midwife. All other health care providers who qualify under the act will receive a 50% abatement of their assessment. As a condition of accepting the abatement, providers must agree to practice in the state for at least one full year following the year for which the abatement was received.⁷⁵ The State of Pennsylvania has extended the abatement one year, to include 2005 MCARE assessments. (Act 154 of 2004).

n. South Carolina

- i. Signed into law by Governor Sanford on April 4, 2005, S.B. 83 establishes a \$350,000 cap on non-economic damages in a medical liability action against a single health care provider or single health care institution. If the award is against more than one health care provider or more than one institution, the total award for non-economic damages cannot exceed \$1.05 million, with each defendant not liable for more

⁷³ H.B. 2661, 49th Oklahoma Legislature, 2nd Reg. Sess. (2004).

⁷⁴ OK CODE §63-1-1708.1F (2004).

than \$350,000. The cap applies separately to each claimant and adjusts annually based on an increase or decrease in the Consumer Price Index.

o. Texas

- i. On June 11, 2003, Governor Perry signed H.B. 4 into law. H.B. 4 contains sweeping tort reforms, many of which exclusively address medical liability litigation against physicians. Of these reforms, perhaps the most important is the hard cap of \$250,000 on non-economic damages per claimant in any judgment against a physician or health care provider, regardless of any applicable theories of vicarious liability, the number of defendants involved, or the number of causes of action asserted as part of the claimant's case against the physician. H.B. 4 also places a hard cap of \$250,000 on non-economic damages per claimant in any judgment against a health care institution in a medical liability cause of action. A judgment against two health care institutions shall not exceed \$500,000 in non-economic damages with each institution not liable for more than \$250,000 in non-economic damages.⁷⁵ All persons claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single claimant.
- ii. The new law states the cap on non-economic damages applies per "claimant." This terminology may create some confusion about the scope of the cap. Fortunately, however, the new law defines "claimant" as "a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single claimant." Therefore, all persons claiming to have sustained damages as a result of injury or death sustained by a single person are considered a single claimant. The new law also states the cap applies regardless of the number of defendants or causes of action asserted.

Therefore, the maximum amount a claimant (including all persons that claim damages as a result of injury or death of a single person) can recover in non-economic damages, even if multiple physician defendants are involved and the claimant asserts multiple causes of action, is \$250,000. There is also a separate cap for health care institutions whereby a claimant can recover up to an additional \$250,000 for one institution and up

⁷⁵ PA H.B. 44 (2004) (enacted).

⁷⁶ TEX. CIV. PRAC. & REM. § 74.301(2004).

to \$500,000 if more than one institution is involved. Again this cap applies regardless of the number of causes of action asserted, or persons who claim to have damages from the injury or death of a single person.

- iii. The caps provision states as follows: "(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based. (b) in an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant. (c) In an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution is, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$500,000 for each claimant."
- iv. On September 13, 2003, the people of Texas approved Proposition 12, a ballot initiative to amend the state constitution to specifically allow the legislature to enact laws that place limits on non-economic damages in medical and health liability cases.⁷⁷ This vote validates the legislature's work in enacting H.B. 4.

⁷⁷ A tribute to the effectiveness of Proposition 12 came soon after its passing when personal injury trial attorney and member of the Oklahoma legislature Stratton Taylor sent a letter to his ATLA colleagues in Texas to offer the services of his firm to any Texas attorney wishing to forum-shop and file suit in Oklahoma—where there are still no caps. Editorial, *Oklahoma!*, THE WALL ST. J., Dec. 19, 2003.

The final vote was 51.12% in favor of Proposition 12 and 48.88% against.

Since passage of Proposition 12 and HB 4, Texas Medical Liability Trust, the largest medical liability carrier in the state, cut premiums by 17%.⁷⁸ The total rate reduction represents \$34 million in savings to physicians and patients in Texas. Since then the next four largest insurers in the Texas medical liability market have also reduced premiums providing Texans with an additional \$16 million in relief.⁷⁹ This includes The Doctors Company's proposed rate reductions of an average of 14% per provider in 2005.⁸⁰

p. West Virginia

- i. Cap on non-economic damages. On March 11, 2003, West Virginia's Governor Bob Wise signed into law H.B. 2122. As enacted, the bill contains a number of reforms including a \$250,000 cap on non-economic damages applied per occurrence regardless of the number of defendants or plaintiffs. The cap increases to \$500,000 per occurrence for cases involving a permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system, or permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. The cap will be adjusted annually for inflation up to \$375,000 per occurrence or \$750,000 for injuries that fall within the exception.⁸¹
- ii. Cap on trauma care. The bill also includes a \$500,000 cap on civil damages for any injury to or death of a patient as a result of health care services rendered in good faith and necessitated by an emergency condition for which the patient enters a health care facility designated as a trauma center. This limit also applies in the following circumstances: (1) to health care services rendered by a licensed EMS agency or employee of a licensed EMS agency. (2) any act or omission of a health care provider in rendering continued care or assistance in the event that surgery is

⁷⁸ Terry Maxon, *No cure-all*, THE DALLAS MORNING NEWS, Sept. 26, 2004; *Malpractice claims drop a year after reforms*, THE ASSOC. PRESS ST. & LOCAL WIRE, Oct. 6, 2004; Joseph T. Hallinan & Rachel Zimmerman, *Malpractice Insurer Sees Little Savings in Award Caps*, THE WALL ST. J., Oct. 28, 2004.

⁷⁹ Texas Alliance for Patient Access.

⁸⁰ *The Doctors Company Announces Rate Decrease in Texas*, PRNEWswire, Feb. 25, 2005.

⁸¹ W. VA. CODE § 55-7B-8 (2004).

required as a result of the patient's emergency condition.

This limit does not apply if the care is rendered in willful and wanton or reckless disregard of a risk of harm to the patient or in clear violation of established written protocols for triage and emergency health care procedures developed by the office of emergency medical services. Likewise, the limit does not apply to any act or omission in rendering care that occurs after the patient has been stabilized and is considered a non-emergency patient, or care that is unrelated to the original emergency condition.

If the physician who provided care to the patient when the patient was presented with an emergency condition provides follow-up care to the same patient and a medical condition arises during the course of this follow-up care that is directly related to the original emergency condition, there is a rebuttable presumption that the medical condition was the result of the original emergency condition, and, therefore, the cap applies. There is also a rebuttable presumption that a medical condition that arises in the course of follow-up care provided by a health care provider in the trauma center is directly related to the original emergency condition, where the follow-up care is provided within a reasonable time after the patient's admission to the trauma center.⁸²

q. Wyoming

During a special session in 2004, Wyoming's legislature enacted a number of meaningful medical liability reforms, including a bill to amend the constitution to allow the legislature to place a cap on non-economic damages in medical liability cases. The issue went before the voters in November, 2004, and Wyoming voters approved one amendment allowing the legislature to pass laws creating medical screening panels or other alternative dispute resolution systems in medical liability cases. During the 2005 legislative session, the legislature enacted H.B. 83, a bill to establish a pre-trial screening panel.

4. Election 2004 Ballot Measures

- a. Four states, Florida, Nevada, Oregon, and Wyoming had ballot initiatives related to medical liability reform that went

⁸² *Id.* at § 55-7B-9C.

before voters on November 2. The following is a summary of these initiatives and what voters decided.

i. Florida

1. Voters approved a constitutional Amendment 3, stating that an injured claimant who enters into a contingency fee agreement with an attorney for a medical liability claim is entitled to no less than 70% of the first \$250,000 and 90% of any damage award over \$250,000. Voters also approved two amendments sponsored by trial attorneys. One of these amendments, Amendment 7, gives the public access to any records made or received by a health care provider or facility related to an adverse medical incident. The other amendment, Amendment 8, denies licensure to a physician who has been “found to have committed” three or more incidents of medical liability. The language “found to have committed” means a finding of a physician’s medical liability by either: (1) a final judgment of a court; (2) a final administrative agency decision; or (3) a decision resulting from binding arbitration. “Found to have committed” does not, therefore, include settlements of medical liability claims. Nor does it include a report to a medical liability insurance carrier that a claim has, or will be, filed.

Amendment 3 is self-executing, which means that it is intended to be effective without subsequent legislative activity. Amendments 7 and 8 will most likely require supplementary legislative activity and clarification before they can be implemented.

ii. Nevada

1. Voters approved the “Keep our Doctors in Nevada” initiative (Question 3) which amends Nevada’s current medical liability reform statute to include MICRA-style reforms. The approved initiative amends Nevada’s existing medical liability reform statute by: (1) deleting the current exceptions to Nevada’s \$350,000 cap on non-economic damages in medical liability cases; (2) strengthening the existing joint

and several liability reform law by applying it to both economic and non-economic damages; (3) requiring periodic payment of future damages over \$50,000 at the request of either party; (4) placing limits on attorney contingency fees; and (5) strengthening Nevada's existing statute of limitations.

Voters also defeated two ballot initiatives (Questions 4 and 5) sponsored by trial lawyers. Question 4 called for auto, homeowners, and medical liability insurers to roll back their rates to the amount charged on December 1, 2005, and reduce them an additional 20 percent. Question 5 focused on frivolous lawsuits. If approved, both measures would have invalidated any medical liability reforms enacted by the legislature or voters, including Question 3.

iii. Oregon

Voters defeated Measure 35, which would have amended the state constitution to establish a \$500,000 cap on non-economic damages in medical liability cases. This \$500,000 cap was passed by the legislature in 1987 and later overturned by the Oregon Supreme Court in 1999.

iv. Wyoming

In Wyoming, voters approved one constitutional amendment, and defeated another. The approved amendment, Amendment C, allows the legislature to pass laws creating medical screening panels or other alternative dispute resolution systems in medical liability cases. The defeated amendment, Amendment D, would have allowed the legislature to enact a cap on non-economic damages in medical liability cases. Wyoming is currently one of four states where the state constitution explicitly prohibits the legislature from enacting limits on damages.

Both amendments were passed by the legislature during a special session in July 2004. For a constitutional amendment to pass in Wyoming, it requires a simple majority of votes cast in the general election. But voters who do not cast a vote either way

for an amendment are counted as “no” votes. This means an amendment sometimes will fail even if it receives over half the votes cast on that ballot question.

5. Judicial Activity

- a. The courts in the following states upheld legislation for caps on non-economic damages: Alaska, California, Colorado, Idaho, Kansas, Maryland, Michigan, Minnesota, Missouri, Nebraska, Utah, Virginia, West Virginia and Wisconsin. (Of them, Missouri, North Carolina, and West Virginia are considered crisis states.)⁸³
- b. Courts in Indiana, Louisiana and New Mexico upheld caps that encompass both economic and non-economic damages.⁸⁴ Louisiana's cap, akin to New Mexico's, does not include medical expenses, which are paid as incurred.⁸⁵
- c. Courts in the following states struck down caps on non-economic damages: Alabama, Illinois, Kansas, New Hampshire, North Dakota, Ohio, Oregon, South Dakota, Washington, and Wisconsin.⁸⁶
- d. In Florida and Texas, caps were upheld, but with some restrictions.⁸⁷

5. Recent Judicial Activity

⁸³ See *Smith v. Botsford*, 419 F. 3d 513 (6th Cir. 2005); *Evans v. State*, 56 P.3d 1046 (Alaska 2002); *Hoffman v. U.S.*, 767 F.2d 1431 (9th Cir. 1985); *Fein v. Permanente*, 695 P.2d 665 (Ca. 1985); *Scholz v. Metro. Pathologists P.C.*, 851 P.2d 901 (Colo. 1993); *Kirkland v. Blaine County Med. Ctr.*, 4 P.3d 1115 (Idaho 2002); *Samsel v. Wheeler Transp. Serv., Inc.* 246 Kan. 336 (Kan. 1990); *Murphy v. Edmunds*, 601 A.2d 102 (Md. 1992); *Zdrojewski v. Murphy*, 657 N.W.2d 721 (Mich. Ct. App. 2002); *Adams v. Children's Mercy Hosp.*, 848 S.W.2d 535 (Mo. Ct. App. 1993); *Linder v. Smith*, 629 P.2d 1187 (Mont. 1981); *Prendergast v. Nelson*, 256 N.W.2d 657 (Neb. 1977); *Gourley ex. rel. Gourley v. Neb. Methodist Health Sys.*, 633 N.W.2d 43 (Neb. 2003); *Judd v. Drezga*, 103 P.3d 135 (Ut. 2004); *Etheridge, et. al. v. Med. Ctr. Hosp.*, 367 S.E.2d 525 (Va. 1989); *Robinson v. Charleston Area Med. Ctr.*, 186 W.Va. 720 (W. Va. 1991); *Verba v. Ghaphery*, 552 S.E.2d (W. Va. 2001); *Guzman v. St. Francis Hosp.*, 623 N.W.2d 776 (Wis. Ct. App. 2000), *Maurin v. Hall*, 682 NW2d 866 (Wis. 2004), *but see Ferdon v. Wis. Patients Comp. Fund*, 2005 WI 125 (Wis. 2005).

⁸⁴ *Johnson v. St. Vincent Hosp.*, 404 N.E.2d 585 (Ind. 1980); *Butler v. Flint Goodrich Hosp.*, 607 So.2d 517 (La. 1992), *Fed. Express Corp. v. U.S.*, 228 F. Supp. 2d 1267 (N.M. 2002).

⁸⁵ LA. REV. STAT. § 40:1299.42(B)(1) (2003).

⁸⁶ See *Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156 (Ala. 1991); *Best v. Taylor Mach. Works*, 689 N.E.2d 1057 (Ill. 1997); *Kan. Malpractice Victims Coalition v. Bell*, 757 P.2d 251 (Kan. 1988) (new law enacted in 1988); *Carson v. Mauer*, 424 A.2d 825 (N.H. 1980); *Arneson v. Olson*, 270 N.W.2d (N.D. 1978); *State ex rel. Ohio Academy of Trial Lawyers v. Sheward*, 715 N.E. 2d 1062 (Oh. 1999); *Lakin v. Senco Products, Inc.*, 987 P.2d 463 (Or. 1999); *Sofie v. Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989); *Ferdon v. Wis. Patients Comp. Fund*, 2005 WI 125 (Wis. 2005).

⁸⁷ See *Univ. of Miami v. Echarte*, 618 So.2d 189 (Fla. 1993); *Lucas v. U.S.*, 757 S.W.2d 687 (Tex. 1988); *Rose v. Doctors Hosp.*, 801 S.W.2d 841 (Tex. 1990).

- a. Wisconsin. In a 4-3 opinion issued July 14, 2005 the Wisconsin Supreme Court struck down Wisconsin's cap on non-economic damages, which has been in place since 1995. Specifically, the Court held that Wisconsin's \$350,000 cap (adjusted for inflation) on non-economic medical malpractice damages set forth in Wis. Stat. §§ 655.017 and 893.55 (4)(d) violated the equal protection clause of Wisconsin's Constitution. In numerous prior cases, the Wisconsin Supreme Court addressed the constitutionality of various provisions in Wis. Stat. §§ 655, including the cap on non-economic damages, upholding the provision as constitutional each time.⁸⁸
- b. Michigan. On August 18, 2005, the U.S. Court of Appeals for the Sixth Circuit upheld Michigan's cap on non-economic damages. Specifically the Court held the cap does not violate the Seventh Amendment or Equal Protection Clause of the U.S. Constitution.⁸⁹
- c. Utah. In an opinion issued November 5, 2004, the Utah Supreme Court upheld Utah's cap on non-economic damages as constitutional. Specifically the Court held the cap does not violate the open courts, uniform operation of laws, or due process provisions of the Utah Constitution. The Court also held the cap does not violate the separation of powers or right to a jury trial as protected by the Utah Constitution.⁹⁰
- d. Indiana. On June 29, 2004, in Indiana, an Indiana appeals court ruled that the statute of limitations applicable to a minor's medical liability cause of action was unconstitutional. The case arose from alleged medical liability committed during a minor plaintiff's birth, which ultimately resulted in the minor suffering serious and permanent physical and mental injuries. At the time the child was born, Indiana law stated that the minor had until she was 20 years old to file a medical liability action for the alleged negligence. The legislature subsequently changed the statute of limitations. Under the change, the minor was required to file her medical liability action by her eight birthday. Unaware of the change in the law, the child commenced suit before his 20th birthday. The trial court ruled that the minor's medical liability claim was barred by the new limitation's period. The appeals court reversed, holding that the change requiring the child's lawsuit to be filed no later than her eight birthday violated Indiana's Constitution. The court based its decision on a finding that the classification

⁸⁸ Ferdon v. Wis. Patients Comp. Fund, 2005 WI 125 (Wis. 2005).

⁸⁹ Smith v. Botsford General Hosp. 419 F.3d 513 (6th Cir. 2005).

⁹⁰ Judd v. Drezga, 103 P.3d 135 (Utah 2004).

between minors injured by medical liability and minor victims of other torts was no longer reasonably related to the goal of maintaining sufficient medical treatment and controlling medical liability insurance costs.

6. Favorable State Case Law Establishes Rationale for Supporting Legislative Reforms - Failed Legal Challenges Brought Against Caps on Non-Economic Damages⁹¹

a. Equal Protection Clause

- i. Under the “deferential rational relationship” test, a number of courts have upheld damages caps as a permissive and rational means of achieving the legitimate state goal of reducing insurance premiums paid by physicians.
- ii. Other societal goals supporting the implementation of caps that have been upheld by the court include; (i) ensuring the availability of physicians in the state, (ii) the continued existence of state compensation funds, (iii) the continued existence of insurance for physicians in the state, and (iv) assurance of medical related payments to all claimants.
- iii. Courts have held it constitutional for damage caps to differentiate between medical liability tort claimants who have suffered injuries valued at a level below the damages cap, and those who have suffered damages valued above the damages cap amount based upon the legitimate purpose of the legislature.

b. Due Process Clause

Court analysis of due process challenges also has proceeded under the rational relationship test, where damages caps have been found to be neither arbitrary nor irrational legislative goals.

c. Right to Trial by Jury

- i. After a plaintiff is awarded damages up to the amount of the statutory cap, the determination of damages is removed from consideration by the jury and given to the court. This is not a denial of the right to trial by jury, since the jury already has completed its fact-finding mission, determining that the plaintiff is owed compensation. Deciding how much a patient will

⁹¹ See cases cited *supra*, note 98.

recover is a question of law for the court. The court implements the policy decision of the legislature.

- ii. Reviewing courts also have held that it is within the legislature's power to modify common law and statutory rights and remedies, as was done with the caps.

d. Open Court Challenge

The courts have struck down the argument that a damage cap impermissibly allows the legislature to intrude on the judicial process. Instead of being an impermissible barrier to the courts, the cap is merely a limit on recoveries.

e. Intrusion on the Rulemaking Power of the Judicial Branch

The courts did not find that caps allow the legislature to overstep its constitutional powers. Instead, the courts found that the legislature has full purview over questions of policy, as opposed to procedural questions. Damage caps are questions of policy, properly within the legislature's scope of power.

7. California's Solution: MICRA

- a. California enacted the Medical Injury Compensation Reform Act of 1975 (MICRA) which largely eliminates the lottery aspect of medical liability litigation in that state.⁹²
- b. Now, in California, claims are settled in one-third less time than in states without caps on non-economic damages.⁹³ This not only decreases the cost of litigation, it also means injured patients are indemnified much faster in California.
- c. California's experience with MICRA shows that tort reform works. MICRA has been held up as "the gold standard" of tort reform, and a model for repeated attempts at Federal reform legislation.
- d. A recent study by the RAND Corporation showed that MICRA was successful at decreasing insurer payouts and redistributing money from trial lawyers to injured patients. MICRA's contingency fee reform and limit on non-economic damages caused plaintiff attorney fees to be

⁹² CAL. CIV. CODE § 3333.2 (2004).

⁹³ *Harming Patient Access to Care: The Impact of Excessive Litigation: Hearing Before the Subcomm. on Health of the Comm. on Energy and Commerce, 107th Cong. 88 (2002)* [hereinafter Anderson statement] (statement of Richard E. Anderson, Chairman of the Doctors' Co. for the Physician Ins. Ass'n of Am.).

reduced 60%, while net recoveries to patients and their families were only reduced 15%.⁹⁴

- e. According to Phil Hinderberger of Norcal Mutual, before MICRA was passed, "California physicians paid almost 25% of all medical liability premiums paid in the [U.S.] at a time when they represented only about 10% of all practicing physicians in the [U.S.]. Today, California physicians pay about [10]% of all medical liability premiums paid in the [U.S.] which represents a fair share."⁹⁵
- f. According to the National Association of Insurance Commissioners, while total premiums in the rest of the U.S. have risen 920% between 1976 and 2003, the increase in California premiums was only 282% over the same time period.⁹⁶
- g. According to HHS, "the percentage of claims resolved through settlement and arbitration has increased in California, saving money for injured patients."⁹⁷ "Premiums for specialists in Los Angeles are substantially less than for specialists in metropolitan areas in states without reforms such as Florida, Illinois, and Nevada."⁹⁸ For example, an Ob-Gyn in Los Angeles can expect to pay approximately \$71,000 per year for liability insurance whereas the same Ob-Gyn would pay nearly \$372,000 in South Florida, and \$134,000 in Chicago or Las Vegas.⁹⁹

⁹⁴ NICHOLAS M. PACE, ET AL., RAND CORP., CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS xxiv (2004).

⁹⁵ Posting of Phil Hinderberger, phil-hinderberger@norcalmutual.org, to asmac-l@unity.ama-assn.org (Jan. 20, 2003) (copy on file with author).

⁹⁶ See e.g., NAT'L ASS'N OF INS. COMM'RS, PROFITABILITY BY LINE BY STATE IN 1976 and 2002 (National Association of Insurance Commissioners Insurance Products & Services Division 2003), at 116-7 (2003). Statistics presented in *MLR – Now!* have been derived from this and previous versions of the report dating back to 1975.

⁹⁷ INSURANCE CYCLE, *supra* note 24, at 4.

⁹⁸ *Id.*

⁹⁹ Med. Liability Monitor, 30 (2005).

C. Federal Legislation

1. Although some states are attempting to address the medical liability crisis at the state level, a federal solution also is needed. Many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reform.
2. The existing crisis is not confined within state lines. Many patients are losing access to their physicians, forcing them to travel to neighboring states for their critical health care services.
3. All patients pay the escalating costs generated by our nation's dysfunctional medical liability system. These costs are especially high for the federal government, given that one-third of the total health care spending in our country is paid by the Medicare and Medicaid Programs.
4. Activities in the U.S. House of Representatives
 - a. 108th Congress
 - i. On February 5, 2003, H.R. 5, the HEALTH Act (Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2003), was introduced in the House of Representatives.
 - ii. H.R. 5, which is modeled after the successful MICRA statute, includes provisions that would –
 1. Ensure that patients receive 100% compensation for their economic losses (including past and future medical expenses, rehabilitation costs, child care costs, loss of past and future earnings, and other quantifiable costs) if harmed by a physician's negligence;
 2. Place reasonable limits on non-economic damages of up to \$250,000 and allow states the flexibility to establish or maintain their own laws on damages, whether higher or lower;
 3. Establish a sliding-scale for attorney's fees, thereby maximizing the recovery of the award for patients; and

4. Establish periodic payments of future damages and a “fair share” rule that allocates damage awards fairly and in proportion to fault.
- iii. On March 13, 2003, the House of Representatives passed H.R. 5 by a vote of 229-196. The vote was largely along party lines: 213 Republicans and 16 Democrats supported the bill; 9 Republicans, 186 Democrats and 1 Independent opposed the bill; 1 Republican voted “present”; and 8 members did not vote.
- iv. H.R. 5 would safeguard patients’ access to care by enacting common sense reforms that provide a \$250,000 cap on non-economic damages, thus reasonably limiting damages without preempting existing state law.
- v. The Supremacy Clause, principles of preemption, and the language of H.R. 5 would protect states with existing caps and provide a federal standard for a non-economic cap, even if such caps are barred by a state constitution.
- vi. A 2003 Congressional Budget Office (CBO) study on H.R. 5 (108th Congress) indicates that certain tort limitations, primarily caps on awards and rules governing offsets from collateral-source benefits, effectively reduce average premiums for medical liability insurance. Consequently, CBO estimates that, in states that currently do not have controls on medical liability torts, H.R. 5 would significantly lower premiums for medical liability insurance from what they would otherwise be under current law.¹⁰⁰
- vi. As part of its “Careers for the 21st Century America” initiative, the House Republican Leadership held another vote on medical liability reform on May 12, 2004. The legislation, H.R. 4280 (the HEALTH Act of 2004), was virtually identical to H.R. 5 and contained only minor technical changes. The AMA strongly supported H.R. 4280, and it passed the House by a vote of 229-197.

b. 109th Congress

¹⁰⁰ CONG. BUDGET OFFICE, H. R. 5 HELP EFFICIENT, ACCESSIBLE, LOW-COST, TIMELY HEALTHCARE (HEALTH) ACT OF 2003 (2003), available at <http://www.cbo.gov/showdoc.cfm?index=4091&sequence=0> (last visited Feb. 10, 2004).

- i. On July 28, 2005, the House debated and passed H.R. 5, the HEALTH Act of 2005, by a 230-194 vote (with 2 voting present). The AMA strongly supported passage of H.R. 5.
- ii. The bill, which provides for fair and reasonable reforms to our medical liability system – including a \$250,000 cap on non-economic damage awards, was virtually identical to legislation passed twice in the House during the 108th Congress.
- iii. On passage, H.R. 5 received bipartisan support with 216 Republicans and 14 Democrats voting in favor of passage.

5. Activities in the U.S. Senate

a. 108th Congress

- i. On June 26, 2003, S. 11, the “Patients First Act of 2003,” was introduced in the U.S. Senate. S. 11 was very similar to H.R. 5, as introduced in the U.S. House of Representatives, and also included a provision to reform expert witness requirements. Like H.R. 5, the AMA strongly supported this bill.
- ii. Despite the strong backing by the Senate Republican Leadership, on July 9, 2003, S. 11 failed to acquire the sixty votes needed to overcome a Democratic filibuster, thereby preventing the Senate from proceeding to a full debate. Forty-nine Senators voted in favor of breaking the filibuster, while forty-eight voted against.
- iii. Shortly after the July 2003 vote, the Senate Republican Leadership again expressed its strong commitment to federal medical liability reform by announcing their intent to bring numerous medical liability reform bills to the floor of the Senate throughout 2004.
- iv. On February 24, 2004, the Senate had a procedural vote on S. 2061, the “Healthy Mothers and Healthy Babies Access to Care Act of 2003.” If enacted, the legislation would have applied certain MICRA-type reforms to physicians who provide obstetrical and gynecological services related to childbirth. The AMA expressed concerns that language in S. 2061 relating to collateral source/subrogation and ERISA scope of preemption (as included in previously introduced legislation, S. 607) could disadvantage patients and physicians. However, the AMA urged a “yes” vote on the procedural vote as a step to advance Senate legislation on medical liability reform. S. 2061

failed to acquire the sixty votes needed to overcome a Democratic filibuster. Forty-eight Senators voted in favor of breaking the filibuster, while forty-five Senators voted against.

- v. On April 7, 2004, the Senate again attempted to advance medical liability reform legislation. This time, the Senate had a procedural vote on S. 2207, the "Pregnancy and Trauma Care Access Protection Act of 2004." If enacted, S. 2207 would apply certain MICRA-like reforms to physicians who provide trauma/emergency services and services related to childbirth. Like S. 2061, this contained the same language regarding collateral source/subrogation and ERISA scope of preemption. The AMA again expressed concerns, but urged a "yes" vote on the procedural motion. S. 2207 failed to acquire the sixty votes needed to overcome a Democratic filibuster. Forty-nine Senators voted in favor of breaking the filibuster, while forty-eight Senators voted against.

b. 109th Congress

- i. The AMA remains strongly committed to enacting federal legislation in the 109th Congress that will provide comprehensive medical liability reform for all physicians.

6. Public Support for Federal Legislation

- a. The American public continues to support medical liability reform.
- b. Seventy-four percent (74%) of those surveyed in a Harris Interactive poll favor a law that would guarantee an injured patient full payment for lost wages and medical expenses and place reasonable limits on awards for "pain and suffering" in medical liability cases. Nearly three-quarters (73 percent) of the Americans surveyed said they wanted their elected representatives in Washington to support comprehensive medical liability reform.¹⁰¹
- c. A Gallup poll confirms this public opinion. The poll results, released February 4, 2003, show that 72% of Americans support limiting the amount patients can be awarded for "pain and suffering."

III. Responding to Other Arguments

¹⁰¹ Health Coalition on Liability and Access, *supra* note 12.

A. Public Citizen and Other Anti-Tort Reform Groups' Concerns

1. Claim: Physicians are victims of insurance companies that made bad business decisions and are now trying to make up their losses.

Fact: Fact: Annual Statement data summarized in Best's Aggregates & Averages, Property-Casualty, 2005 edition, showed that the Investment Yields of medical liability insurers have been stable and positive since 2000. Those returns have ranged from 3.7% to 5.3%, and include income from interest, dividends, and real estate income. The facts simply do not justify placing blame on the insurance industry for an out-of-control legal system.¹⁰²

2. Claim: Insurance companies raise rates when they are seeking ways to make up for declining interest rates and market-based investment losses.¹⁰³

Fact: Annual Statement data summarized in Best's Aggregates & Averages, Property-Casualty, 2005 edition, showed that the Investment Yields of medical liability insurers have been stable and positive since 2000. Those returns have ranged from 3.7% to 5.3%, and include income from interest, dividends, and real estate income. The facts simply do not justify placing blame on the insurance industry for an out-of-control legal system.¹⁰⁴

According to the Ohio Department of Insurance, the vast majority of invested assets are fixed-income instruments such as treasury, municipal, and corporate bonds whose losses have been minimal.¹⁰⁵

The Ohio Department of Insurance also refutes this misconception by stating that there is no provision in its regulations that allows insurance companies to increase their rates in order to recoup past costs resulting from pricing mistakes, larger than expected claims, adverse court decisions, or other unexpected costs.¹⁰⁶

Brown Brothers Harriman & Co. (BBH) completed a study ("Did Investments Affect Medical Malpractice Premiums?") that analyzed the impact of insurers' asset allocation and investment income on the premiums they charge. BBH concluded that there is no correlation between the premiums charged by the medical liability insurance industry, on the one hand, and the industry's investment yield, the performance of

¹⁰² AM BEST, BEST'S AGGREGATES & AVERAGES - PROPERTY/CASUALTY, QUANTITATIVE ANALYSIS REPORT, MED. QUANTITATIVE ANALYSIS REPORT, MED. MALPRACTICE PREDOMINATING: 2005 ed. (2005), at 140.

¹⁰³ See e.g., AMERICANS FOR INS. REFORM, MED. MALPRACTICE INS.: STABLE LOSSES/UNSTABLE RATES 7 (2002), available at <http://www.insurance-reform.org/StableLosses.pdf> (last visited Feb. 12, 2004).

¹⁰⁴ AM BEST, BEST'S AGGREGATES & AVERAGES - PROPERTY/CASUALTY, QUANTITATIVE ANALYSIS REPORT, MED. MALPRACTICE PREDOMINATING: 2005 ed. (2005), at 140.

¹⁰⁵ Holly Saelens, Medical Malpractice Insurance, Address on behalf of the Ohio Dept. of Ins.

¹⁰⁶ *Id.* at 18.

the U.S. economy, or interest rates, on the other hand.¹⁰⁷

In addition, BBH conducted a follow-up study that analyzed National Association of Insurance Commissioners (NAIC) data to answer the question: "Did medical malpractice companies raise premiums because they had come to expect a certain percentage gain that was not achieved due to market conditions?" BBH determined that the decline in equities (which are a small percentage of insurance company investments) was more than offset by the capital gains by bonds (which make up a substantial part of insurance company investments) due to a decline in interest rates. BBH concluded that "investments did not precipitate the current crisis."¹⁰⁸

3. Claim: The crisis is nothing more than the natural "insurance cycle."

Fact: It is not the underwriting cycle that drives the problem, but the growing size of jury awards. The U.S. Department of Health and Human Services argues that if the insurance cycle were the cause of the current crisis, "then all states would be equally experiencing a crisis."¹⁰⁹ Insurers are not leaving other lines of insurance markets. They are leaving the medical liability insurance market because of the risk of unbounded payouts in that sector, particularly in non-reform states.¹¹⁰ As a case in point, "St. Paul Companies, which was the largest medical liability carrier in the U.S. (covering 9% of physicians), announced in December of 2001 that it would no longer offer coverage to any doctor in the country."¹¹¹

4. Claim: The crisis is due to lack of insurance regulation by the states.

Fact: The American Association of Health Plans (AAHP) finds that "all state insurance departments and other state governmental agencies heavily regulate and monitor the solvency of medical malpractice carriers...and require extensive reporting."¹¹² These regulators place strict limits on the types and riskiness of investments insurers can purchase. Also, the insurers are required to report annually on the status of their investments. The fact remains that in states without medical liability reforms, insurers are choosing to no longer write policies or to leave the state altogether. A state's level of insurance regulation does nothing to regulate the main

¹⁰⁷ Raghu Ramachandran, *Did Investments Affect Medical Malpractice Premiums?*, Jan. 21, 2003, available at <http://salsa.bbh.com/news/Articles/MedMal.html> (last visited Feb. 3, 2004).

¹⁰⁸ Raghu Ramachandran, *A Note on Investment Income of Medical Malpractice Companies*, Feb. 4, 2003, available at <http://salsa.bbh.com/news/Articles/medmal2.html> (last visited Feb. 3, 2004).

¹⁰⁹ INSURANCE CYCLE, *supra* note 24, at 1.

¹¹⁰ *Id.* at 3.

¹¹¹ *Id.*

¹¹² AM. ASS'N OF HEALTH PLANS, "LAWSUIT LOTTERY" CAUSES MED. MALPRACTICE CRISIS—SUGGESTIONS THAT POOR INVESTMENTS LED TO CRISIS DON'T PASS SMELL TEST 1, available at <http://www.americanbenefitscouncil.org/documents/refutingstockmarketargument.pdf> (last visited Feb. 12, 2004).

driver of increasing medical liability premiums – increasing severity of jury awards and settlements.¹¹³

5. Claim: The crisis is a result of bad insurer investment practices, including putting too much money in the stock market.

Fact: The AAHP also reasoned that if the stock market were to blame, the crisis would resonate across the country to all medical liability insurers. This is not the case, as evidenced by the fact that it is mostly physicians that practice in states without meaningful medical liability reform who are significantly affected.¹¹⁴ Furthermore, as noted elsewhere in this document, insurers do not heavily invest in the stock market. Rather, insurers' investments are mostly in bonds and other positive-yield markets.¹¹⁵

- B. Proposition 103 Myth: "Proposition 103, not MICRA, is responsible for lowering medical liability premiums in California."

(The information in this section is derived in part from the American Medical Association's Proposition 103 Myth document).

1. Fact: Proposition 103 is not responsible for keeping California's medical liability premiums down. Rather, MICRA has been the force behind California's success.
 - a. In 1975, California's legislature enacted MICRA, the "Medical Injury Compensation Reform Act"—thirteen years before the passage of Proposition 103 in 1988.
 - b. MICRA reformed the state's medical liability system and included a \$250,000 cap on non-economic damages. A recent report by the U.S. General Accounting Office (GAO) and other studies have shown that states with caps on non-economic damages have experienced slower premium growth than states with more limited reforms.
 - c. MICRA has been the driving force that has kept premiums one-half to one-third below premiums in states without caps on non-economic damages and similar reforms.
 - d. According to National Association of Insurance Commissioners data, California's medical liability premiums have increased 282% between 1975, when MICRA was enacted, and 2003, while the rest of the nation's premiums have increased 920%.

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ See e.g., *Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care?: Hearing Before the Subcomm. on Commercial and Admin. Law of the Comm. on the Judiciary, 107th Cong. 64* (2002) (statement of Lawrence E. Smarr, Pres. of Physician Ins. Ass'n of Am.).

2. Fact: Proposition 103 does not cover all entities that offer insurance.
 - a. Only about one-half of medical providers in California are insured by entities that are subject to Proposition 103.
 - b. The remaining half of medical providers are covered by a combination of risk retention groups and self-insured institutions, both public and private, that are not subject to Proposition 103.

3. Fact: Proposition 103 did not have any substantial effect on liability premiums.

At the time of Proposition 103's passage in 1988, MICRA had been declared constitutional, and liability premiums in California already had begun to stabilize due to insurers' confidence that the courts were beginning to uniformly apply MICRA.

4. Fact: Proposition 103 does not prohibit increases in premiums, it only requires that the increases are justified and are not "excessive, inadequate, or unfairly discriminatory."
 - a. Under Proposition 103, the California Department of Insurance must grant a hearing for a challenge to any increase above 15 percent for commercial lines of insurance.
 - b. Since passage of Proposition 103, few public hearings have been held challenging rate increases for medical liability insurers. The bottom line is that medical liability insurers writing policies for California physicians do not need to increase rates dramatically because the market is under control.

C. Myths Raised by Opponents of Medical Liability Reform in Relation to H.R. 5, the "HEALTH Act"

(The information in this section is derived in part from the American Medical Association's H.R. 5 Myth/Fact document).

1. Myth: Capping non-economic damages prevents patients from adequately recovering for their injuries.

Fact: The HEALTH Act does not limit the amount a patient can receive for economic injuries. An injured patient can recover all of her medical costs, lost wages, future lost wages, rehabilitation costs, and any other economic out-of-pocket loss suffered as a result of a health injury.